Meridian Health Center, LLC
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Licensed Acupuncturist
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Confidential Client Intake Form

Name ____
Phone (Home) ______________ (Work) ______________ (Cell) ______________
Street ____
City/State/Zip ____
Age __________ Date of Birth ______________________ Sex ______________
Email Address ____
Insurance Company ____
Policy No. ______________________ Group No. ______________________
Social Security No. ______________________ Occupation ______________________
Subscriber Name ______________________ Relationship to Patient ______________________
Referred By ____
In Emergency Notify ______________________ Phone ______________________
Family Physician ______________________ Phone ______________________
Have you been treated with massage or acupuncture before? ______________________

Main problem(s) that you want help with ____

____

How long ago did this problem begin? ____

Have you been given a diagnosis for this problem? If so, what? ______________________

List any stress reduction and exercise activities. Include frequency. ______________________

____

List current medications, including herbal remedies, aspirin, etc. ______________________

____

Past Medical History (include dates) ____

____

Significant Illnesses:

- ❍ Cancer
- ❍ Diabetes
- ❍ Hepatitis
- ❍ High Blood Pressure
- ❍ Heart Disease
- ❍ Thyroid Disease
- ❍ Seizures
- ❍ Venereal Disease
- ❍ Other: ______________________

Surgeries ____

____

Significant Trauma (auto accidents, falls, etc.) ____

____

Allergies (drugs, chemicals, foods) ____

____

Please mark any of the following that you now have, or have had in the past (indicate side of body where necessary):

Musculoskeletal

- ❍ Bone or joint disease
- ❍ Tendonitis/bursitis
- ❍ Arthritis/gout
- ❍ Sprains/strains
- ❍ Low back/hip/leg pain
- ❍ Neck/shoulder/arm pain
- ❍ Spasms/cramps
- ❍ Jaw pain/TMJ
- ❍ Lupus
- ❍ Osteoporosis
- ❍ Other: ___________________

Nervous System

- ❍ Shingles
- ❍ Numbness/tingling
- ❍ Trigeminal Neuralgia
- ❍ Bell's Palsy
- ❍ Pinched Nerve
- ❍ Other: ___________________

Digestive

- ❍ Constipation
- ❍ Gas/bloating
- ❍ Irritable bowel syndrome
- ❍ Ulcers
- ❍ Other: ___________________

Skin

- ❍ Allergies
- ❍ Rashes
- ❍ Athlete's foot
- ❍ Herpes/cold sores
- ❍ Other: ___________________

Reproductive

- ❍ Pregnant: stage____________
- ❍ Ovarian/menstrual problems
- ❍ PMS
- ❍ Endometriosis
- ❍ Prostate problems
- ❍ Other: ___________________

Respiratory

- ❍ Breathing difficulty/asthma
- ❍ Emphysema
- ❍ Allergies
- ❍ Sinus Problems
- ❍ Other: ___________________

Circulatory

- ❍ Heart condition
- ❍ Phlebitis/varicose veins
- ❍ High/low blood pressure
- ❍ Other: ________________________

Other

- ❍ Cancer/tumors
- ❍ Kidney/bladder ailment
- ❍ Drug/alcohol/caffeine/tobacco use
- ❍ Chronic fatigue
- ❍ Chronic pain
- ❍ Sleep disorders
- ❍ Migraines/headaches
- ❍ Anxiety/stress syndrome

Please check all that apply today

- ❍ Contact lenses (hard or soft?)
- ❍ Infection
- ❍ Inflammation/swelling
- ❍ Fever
- ❍ Communicable disease

(please specify): ________________
____

Additional Client Remarks/Comments ____
____
____

Acupuncture / Massage Therapy Policies

❶ Please fill out paperwork prior to your first acupuncture or massage therapy treatment, or arrive 10 minutes early so that it does not cut into your time.

❷ It is expected that you disrobe for your treatment. The only exposure will be the area that is being worked on. This is for comfort and efficiency throughout your treatment.

❸ Please arrive for your treatment clean and showered.

❹ Please do not wear any perfume for your treatment. Deodorant is okay.

❺ The one hour scheduled treatment includes time for paperwork, interviewing and changing sheets.

Because a massage therapist/acupuncturist must be aware of any existing physical conditions that I have, I have listed all my know medical conditions and physical limitations and will inform the massage therapist/acupuncturist in writing of any change in my physical health. I understand that a massage therapist/acupuncturist neither diagnoses illness, disease, or any other medical, physical, or emotional disorder, nor performs any spinal manipulations. I am responsible for consulting a qualified physician for any physical ailment that I have.

Signed: ____ Date: _____________________________________

(patient or responsible party)

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Financial Disclosure

Thank you for choosing me as your health care provider. I am committed to successfully treating you. The following is a statement of my financial policy that I require you to read, agree to and sign prior to receiving treatment. All patients must also complete the Confidential Client Intake Form prior to receiving treatment. Full payment is due at the time of service, unless other arrangements have been made and stated herein. Cash and checks are acceptable methods of payment.

Alternative Arrangement

____ Initials ______________________

If you have insurance coverage, payment will be insurance co-pays and moneys to be applied towards the deductible. Your co-payment and/or deductible will be estimated based on the benefit quote from your insurance company. Ultimately, it is your responsibility to check with your insurance company to see if your plan covers acupuncture/massage therapy, and what your yearly benefit is. Concerns about coverage for services are between you and your insurance carrier. I am not an employee of any insurance carrier. If your yearly insurance benefit for acupuncture/massage therapy has been fulfilled, you will be responsible for all fees incurred for my services, until your benefit period renews.

Final payments will be based on the explanation of benefits form that I receive from your insurance company. Any difference between your original payment and the actual patient responsibility listed on the form will be either refunded, or due at that time.

You must give 24 hours notice if you cancel your appointment for these sessions. If you fail to give 24 hours notice, you will be billed a penalty of $25.

A legal guardian must accompany a minor (patient under 18) in order for the minor to receive non-emergency treatment. Alternative arrangements must be made, in advance of the appointment, if this is not possible.

Acupuncture/massage therapy is an integral part of your rehabilitation program and/or wellness program.

Any feedback or suggestions about my services are always welcomed and encouraged. Thank you in advance for your understanding and compliance with these policies.

I have read, understand, and agree to the above policies regarding services for acupuncture/massage therapy and the associated co-payments and/or deductible payments.

Signed: ___________________________________ Date: ________________________________
(patient or responsible party)